FINAL REPORT
OF THE
INTERIM STUDY COMMITTEE ON
MEDICAID OVERSIGHT

Indiana Legislative Services Agency
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November, 2000

Interim Study Committee on Medicaid Oversight

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November 1, 2000

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FINAL REPORT

Interim Study Committee on Medicaid Oversight

I. LEGISLATIVE COUNCIL DIRECTIVE

The Legislative Council directed the Committee to do the following:

(1) Study whether the claims processing contractor used by the Office of Medicaid Policy and Planning (OMPP) has properly performed the terms of its contract with the state.
(2) Study and make recommendations concerning administrative procedures needed to eliminate Medicaid claims reimbursement backlogs, delays, and errors.
(3) Study and make recommendations concerning the implementation of a case-mix reimbursement system designed for Medicaid certified nursing facilities developed by OMPP.
(4) Study any other matter related to the Medicaid system in Indiana.

II. INTRODUCTION AND REASONS FOR STUDY

The Select Joint Committee on Medicaid Oversight was a statutory committee with an expiration date of December 31, 1999. The expiration date was extended for two years to December 31, 2001, in HEA 1130 (2000). HEA 1130, containing provisions in addition to the extension of the Select Joint Committee, was subsequently vetoed by the Governor. Consequently, the Legislative Council established the Interim Study Committee on Medicaid Oversight with the same charge as existed for the Select Joint Committee.

The Select Joint Committee on Medicaid Oversight was in existence for several years, established initially because of a problem with the Medicaid claims processing system for reimbursing Medicaid providers. The Select Joint Committee was later continued in order to oversee the development and implementation of the Case-Mix system for reimbursing nursing facilities. In addition, the Medicaid program accounts for a significant portion of state expenditures while affecting many citizens and health care providers in all areas of the state thus warranting continued oversight by the General Assembly.

III. SUMMARY OF WORK PROGRAM

The Committee met five times during the 2000 interim: July 24, August 25, September 13, October 11, and October 25.

Issues covered in the first meeting on July 24, 2000, were the following:
(1) Reviewed functions contracted out by OMPP.
(2) Reviewed recent activities of the Medicaid Advisory Committee.

(3) Received an update from EDS, the state's Medicaid claims payment processor.
(4) Received public testimony.

Issues covered in the second meeting on August 25, 2000, were the following:

(1) Received an update from EDS.
(2) Long term care issues, including a discussion of staffing levels in nursing facilities and issues in adult foster care and assisted living.
(3) Medicaid reimbursement levels, including reimbursement for waiver services and for hemophilia drug products.
(4) Issues about the Traumatic Brain Injury Waiver.
(5) Expiring legislation, including Medicaid reimbursement in hospital emergency rooms and cost-based reimbursement of community health centers.

Issues covered in the third meeting on September 13, 2000, were the following:

(1) Medicaid managed care access to drugs.
(2) Review of the proceedings of the Long Term Care Task Force that advises OMPP on waiver changes for assisted living and adult foster care.
(3) Hemophilia drug reimbursement issue.
(4) Reimbursement rates for Medicaid waiver services and for home health services in the regular Medicaid program.
(5) Received public testimony.

Issues covered in the fourth meeting on October 11, 2000, were the following:

(1) Discussion of HEA 1130 (2000), vetoed by the Governor, involving Medicaid reimbursement levels.
(2) Medicaid managed care access to drugs.
(3) Review of an issue involving a sub-contractor in the Medicaid Risk-Based Managed Care (RBMC) program and one of the sub-contractor's providers.

Issues covered in the fifth and final meeting on October 25, 2000, included the following:

(1) Hoosier Healthwise provider and consumer satisfaction surveys.
(2) Update on the Case-Mix Reimbursement System.
(3) Reimbursement for Pharmaceuticals.
(4) Consideration of proposed legislation.
(5) Consideration of the final report.

IV. SUMMARY OF TESTIMONY

The Committee heard testimony on several issues.

Review of functions contracted out by OMPP - The Committee received an overview

from OMPP regarding the various Medicaid and Children's Health Insurance Program (CHIP) functions for which OMPP contracts with third parties to provide. The functions include the following: (1) fiscal agent and related operations, (2) rate-setting and auditing contract monitoring, (3) managed care contract monitoring, (4) data management and analysis contract monitoring, and (5) various contracts within the CHIP program.

Review of recent activities of the Medicaid Advisory Committee - The Committee received an overview from Mr. Jim Jones, Chair of the Medicaid Advisory Committee (MAC), on the recent activities of that committee. Mr. Jones described the membership and that the MAC serves in an advisory role to OMPP and to the Children's Health Policy Board. OMPP brings rules to the MAC before publishing them. OMPP also provides quarterly reports to the MAC. Mr. Jones also told of OMPP exceeding budget projections due to: (a) higher enrollment for CHIP than was anticipated, (b) an aggressive effort to get people off welfare and now some of those people were re-entering the program, and (c) pharmacy costs continuing to increase because of an aging population and the development of new, more expensive drugs. Mr. Jones also described two issues that will be priorities of OMPP: (a) the level of physician reimbursement rates will need to be addressed again because these rates have not increased since 1991, and HEA 1130 (2000), that would have increased rates, was vetoed by the Governor; and (b) the impact of HIPAA (the federal Health Insurance Portability and Accountability Act of 1996).

Receipt of updates by EDS - The Committee received updates from EDS regarding aspects of their claims payment process, including claims payments, denials, adjustments, days for adjudication, number of recipients, and number of enrolled and participating providers. Data on dental services, providers, and recipients, as well as customer assistance phone volume were also provided.

Long Term Care Issues - The Committee received testimony on two issues regarding long term care: (1) staffing levels by certain providers in the Medicaid program; and (2) assisted living and adult foster care services in the Medicaid waiver program.

Testimony suggested that one of the most pressing concerns in the nursing home industry currently is staffing. The average age of the nursing workforce has increased due to a decline in popularity of nursing as a career and because of alternative employment possibilities, as well as other reasons. The Committee was told that the options that might improve the supply of nurses include the following: (1) higher wages; (2) tuition forgiveness; and (3) more aggressive recruiting of nurses from outside Indiana. Testimony indicated that if minimum staffing levels are mandated, there would be a significant impact on nursing facilities, both in terms of non-compliance by facilities and from the financial impact. Testimony also suggested consideration of a wage pass-through whereby additional Medicaid reimbursement is provided to nursing facilities specifically for increasing the wages of certain staff.

Testimony was also received regarding the process used by OMPP in seeking input on changes to the Medicaid waiver program. A new waiver is being developed to provide assisted living and adult foster care services. In addition, the existing Aged and Disabled waiver is being amended to expand adult day care services as required by HEA 1197 (2000). As part of the process, the Governor appointed a Long Term Care Task Force, consisting of consumers and providers, to assist the administration in development of guidelines for the new waiver and the amendment. Concerns were expressed about the time line and about the consultant hired by OMPP to help with the process.

Medicaid Reimbursement Levels - The Committee received testimony on the issue of Medicaid reimbursement levels. Testimony centered on reimbursement rates for the following areas: (1) Medicaid waiver services, generally; (2) waiver services for home health care, specifically for high-tech/ventilator patients; (3) waiver services for traumatic brain injury patients; (4) home health care services in the regular Medicaid program; (5) hemophilia drug products; and expiring legislation involving (6) physician reimbursement in hospital emergency rooms; and (7) cost-based reimbursement for community health centers. Testimony claimed that low reimbursement rates were contributing to the problem of a shortage of nurses, care staff, and service providers in the Medicaid program and, ultimately, to reduced access to Medicaid services and drug products.

Medicaid managed care access to drugs - The Committee heard testimony from OMPP regarding recent actions taken by the Drug Utilization Review (DUR) Board and the status of drug formularies used by the Medicaid managed care organizations. OMPP reported on the DUR process and the role of the DUR Board. Discussion also centered on the role of drug formularies and their impact on physician behavior, the problem of antibiotic resistance, and on client access to drugs.

Medicaid RBMC program - Testimony was received concerning a dispute between Gary Methodist Hospital and Managed Health Services (MHS), sub-contractor to Maxicare in the northern Indiana region in the Medicaid RBMC program. A status report on the dispute resolution was provided at the final meeting of the Committee. A consensus had been reached on the following: (1) a process was developed for identifying eligibility cases to present to the state for resolution; (2) a process was developed for submitting and processing current and future disputed claims; (3) a process was developed for identifying payment for "observation only " versus "inpatient stay;" (4) a process was developed for finalizing review of the "Greenbar" report; (5) finalized payment process for 15 inpatient accounts appealed by Methodist Hospital; (6) effective November 1, 2000, MHS will pay true emergencies at $134.33 (plus ancillaries); (7) established a process to prepare for arbitration of claims that remain in dispute; and (8) contact people for communications were identified.

Issues still unresolved include the following: (1) definition of "true" emergencies; (2) payment rates for "non-emergency" emergency room visits; (3) a process for

determining interest payments; (4) an MHS explanation of recoupments; (5) a dispute resolution process for pre-SEA 455 claims; and (6) the treatment of Methodist Southlake.

Gary Methodist Hospital and MHS were to continue trying to resolve their differences.

Testimony suggested there were conclusions which could be drawn from this problem: (1) It is appropriate for the General Assembly to look at tools that OMPP can use to discipline contractors that are not compliant with the rules and laws; (2) it is appropriate for the General Assembly to look at tools that OMPP can use to make certain bidders ineligible for a contract based on past behavior; and (3) there is a flaw in SEA 455 (2000) which needs to be fixed regarding the arbitration of disputed claims (SEA 455 was a bill specifically addressing the situation between Gary Methodist and the managed care organization).

Hoosier Healthwise Program - FSSA updated the Committee on provider and consumer satisfaction surveys conducted for the Hoosier Healthwise program. The surveys are conducted annually to assess the attitudes, behaviors, and perceptions of the Hoosier Healthwise program by the participating primary care medical providers and members. The surveys are conducted by Market Measurement, Inc., a consulting firm under contract with FSSA.

Case-Mix Reimbursement System - OMPP provided the Committee with a status report on the case-mix reimbursement system two years after implementation. Some of the accomplishments over the last two years were reported to include the following: successful claims payment upon implementation; establishment of a Workgroup that meets regularly; rate-setting process improvements and elimination of backlogs; extensive provider training and educational audits; establishment of a state-of-the-art MDS ("minimum data set") audit program that providers helped to design; a leveling out of expenditures; completion of an Alzheimer's Disease time study; compilation of a nursing facility resident fact book; collaboration with the Indiana State Department of Health on overlapping issues; improved cost coverage; as well as others. OMPP also reported that there is evidence of providers accepting patients with higher needs, one of the primary goals of the system.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Committee made the following findings of fact:

Regarding the reimbursement of hemophilia drug products:

- The change in the price data reported by First DataBank and used by OMPP in the methodology for establishing reimbursement rates for hemophilia drug products has resulted in reimbursement levels that are near or below the cost of acquisition by home health care providers.

- Home health care providers who are currently providing the hemophilia drug to Medicaid recipients in their homes will find it increasingly difficult, if not impossible, to continue to do so.
- If Medicaid recipients are not able to have access to hemophilia drugs in their homes, the recipients will be forced to obtain the drug as a hospital inpatient or in hospital emergency rooms potentially resulting in a slower response in a more expensive setting and in a setting where the entire array of blood factor products are not always in stock.

The Committee made the following recommendations:

Regarding the reimbursement of hemophilia drug products:

- The Committee made a formal recommendation to the Legislative Council that the Council urge the Governor to impose an immediate moratorium on the use of the rate schedule based on the new data until more accurate data on which to base reimbursement can be obtained. [Note: OMPP reported at a later meeting that OMPP had reverted to the old rate schedule in place on May 1, 2000, and that hemophilia drugs would be reimbursed at that rate retroactive to May 1.]

The following bill drafts were considered and approved by the Committee.

HEA 1130 (2000) - Medicaid and Other Health Payments. This bill requires that payment for emergency services provided to certain individuals in a hospital's emergency department for the evaluation or stabilization of an emergency medical condition must be equal to the current Medicaid fee for service reimbursement rates for emergency services. This bill also requires OMPP to base adjustments to payment rates for certain providers that are reimbursed through the resource based relative value scale (RBRVS) on relative value units, factoring in particular cost indices and conversion factors. It also requires OMPP to update these payment rates at least once every two years.

The bill limits payments that a court may order to be made from a county general fund to facilities for the comfort and care provided to certain mentally ill individuals. The bill also requires OMPP to make additional payments to certain providers during state fiscal year 2001 that increase state expenditures by not less than $2,000,000. The bill also reestablishes the Select Joint Committee on Medicaid Oversight. FSSA is required by the bill to submit proposals regarding certain Medicaid waivers to the Select Joint Committee for review before submitting the proposals to the federal Health Care Financing Administration (HCFA).

The motion to recommend an override of the Governor's veto was properly moved and seconded. The motion passed unanimously by a vote of 11 in favor to zero against.

PD 3590 - Disputed Medicaid Hospital Claims. This bill requires that a Medicaid claim submitted for payment by a Lake County disproportionate share hospital be treated as a disputed claim, for purposes of arbitration, under certain circumstances.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of eight in favor to three against. Members indicated that further clarification will need to be made after the bill is introduced.

PD 3576 - Directing of Medicaid Patients to Certain Hospitals. This bill removes the December 31, 2000, expiration date of a provision that: (1) prohibits a Medicaid managed care contractor from providing incentives or mandates to primary medical providers to direct certain Medicaid recipients to contracted hospitals other than a hospital in a city where the recipient resides; and (2) requires certain Medicaid hospitals to comply with eligibility verification and medical management programs negotiated under the hospital's most recent contract or agreement with the Medicaid managed care contractor.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to one against.

PD 3577 - High Tech Home Health Services and Medicaid. This bill defines "high technology home health services" as home health services provided to an individual whose medical needs require high resource utilization. The bill requires OMPP to establish certain payment rates for high technology home health services and to increase these rates annually by the increase in the hospital wage index published by the federal Health Care Financing Administration.

The following changes to the original draft were approved by consent.

Page 1, line 12, between "following" and "payment" insert "maximum."
Page 1, line 18, delete "increase" and insert "review."
Page 1, line 19, delete "by the increase in the hospital wage index published" and insert "."
Page 1, delete line 20.

The motion to recommend the amended bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to one against. The digest of the recommended draft will be changed to reflect the changes approved by the Committee.

PD 3471 - Health Center Cost Based Reimbursement. This bill extends for two years a provision that: (1) adds services provided by certain federally defined community health centers to the services that are provided under Medicaid; (2) requires that each community health center continue to receive its total reasonable cost reimbursement

rate for providing care to recipients of Medicaid; and (3) requires rural health clinics to be reimbursed under a cost-based methodology.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against.

PD 3472 - Medicaid Payment for Emergency Room Services. This bill extends for two years a statute requiring that, under the Medicaid Primary Care Case Management Program (PCCM), physician services provided to a program enrollee in a hospital emergency department must be at a rate of 100% of rates payable under the Medicaid fee structure, if the service is authorized by the enrollee's primary medical provider.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against.

PD 3300 - Select Joint Commission on Medicaid Oversight. This bill establishes the Select Joint Commission on Medicaid Oversight. The bill also provides for the appointment of Commission members and establishes meeting procedures. The bill provides that the Commission operates under the policies of the Legislative Council, except that the Commission may meet at any time during the calendar year and is not required to file an annual report.

The motion to recommend the bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of nine in favor to zero against. Members indicated that this bill would not be needed if the Governor's veto of HEA 1130 (2000) is overridden.

PD 3589 - Medicaid Drug Formularies. This bill defines "therapeutic classification." The bill also provides that a drug formulary adopted by the Medicaid program or a Medicaid managed care organization (MCO) must provide for at least two therapeutically equivalent drugs within each therapeutic classification on the formulary. The bill provides that the Medicaid program or a Medicaid MCO may require prior approval of a drug only to restrict access to single source drugs that are subject to clinical abuse or misuse. The bill also provides criteria for the Drug Utilization Review (DUR) Board to consider in determining whether to approve a Medicaid MCO's proposal to remove or restrict a single source drug. The bill also provides that a Medicaid MCO may remove or restrict a single source drug only under certain conditions. It also requires the DUR Board to review the criteria used by an MCO in determining whether a drug is subject to clinical abuse or misuse.

The following changes to the original draft were approved by consent.

Page 2, line 18, reset in roman "alternative."
Page 2, line 19, delete "therapeutically equivalent."
Page 3, line 33, reset in roman "alternative."

Page 3, line 34, delete "therapeutically equivalent."
Page 3, line 41, delete "review the criteria used by the" and insert "**make a determination that the prior approval meets the requirements of subsection (l).**"
Page 3, delete lines 42 through 43.
Page 5, line 12, delete "Except as provided in."
Page 5, line 13, delete "subsection (g), if" and insert "If."
Page 5, delete lines 17 through 20.
Page 5, line 21, delete "(h)" and insert "**(g).**"

The motion to recommend the amended bill for passage by the General Assembly was properly moved and seconded. The motion passed by a vote of eight in favor to one against. The digest of the recommended draft will be changed to reflect the changes approved by the Committee.

The motion to approve the final report with minor changes was properly moved and seconded. The motion passed by a vote of eight in favor to zero against.

W I T N E S S L I S T

Mr. Steve Bassett, Hemophilia of Indiana, Inc.
Ms. Judith Becherer, Director of Long Term Care Services, OMPP
Mr. Lou Belch, KWK Management Group
Ms. Carol Caldwell, Indiana Psychological Association
Mr. John Cardwell, Citizens Action Coalition
Ms. Linda Chavez, Interim Health Care, Inc.
Ms. Claudia Chavis, Caregiver, Inc.
Ms. Deborah Daniels, representing Gary Methodist Hospital
Ms. Melissa Durr, Indiana Association of Area Agencies for the Aging
Dr. William Engle, American Academy of Pediatrics
Mr. Ron Ferguson, Option Care, Inc.
Ms. Glenna Gebauer
Ms. Kathy Gifford, Office of Medicaid Policy and Planning
Mr. Tom Gutwein, American College of Emergency Physicians
Ms. Stella Hahn, Michigan City, IN
Mr. Charles Hiltunen, Hiltunen Communications
Ms. Maureen Hoffmeier, Indiana Academy of Family Physicians
Mr. Jim Jones, Chair of the Medicaid Advisory Committee
Dr. Michael Kays, Purdue University
Mr. Tim Kennedy, Hall, Render, Killian, Heath, and Lyman
Ms. Faith Laird, Indiana Health Care Association
Ms. Carol Lazarek, Michigan City, IN
Mr. Jim Leich, Indiana Association of Homes and Services for the Aging
Ms. Penny Lewis, Indiana Brain Injury Association
Ms. Karen Lloyd, Ice Miller
Ms. Jean MacDonald, Indiana Association for Home and Hospice Care, Inc.
Mr. Vince McGowan, Indiana Health Care Association
Mr. Mike McKinney, Managed Health Services, Inc.
Ms. Jill Moberly, Bloomington, IN
Mr. Grant Monahan, Indiana Retail Council
Ms. Donna Mumaw, APEX Therapeutic Care, Inc.
Rep. Scott Pelath, LaPorte, IN
Mr. Jim Rickter, HemaSource
Dr. George Rubeiz, Indianapolis, IN
Ms. Nancy Schweller, Rolling Prairie, IN
Ms. Vicky Schweller, Union Mills, IN
Ms. Linda Simers, Osgood, IN
Ms. Mary Simpson, EDS
Ms. Sharon Steadman, OMPP
Ms. Jackie Steuerwald, Preferred Home Care, Inc.
Mr. Carl Weixler
Mr. Jim Young, Indiana Brain Injury Association